MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05452

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Ocean City R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Worcester
City or town: Ocean City R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Harry Grant Babylon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of husband or wife: Carrie B. Babylon.
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 7, 1871

8. AGE: Years 73 | Months 5 | Days | If less than one day: hrs. min.

9. Birthplace: Frizzleburg, Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business

FATHER
12. Name: Josiah Babylon.
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Tabitha Warfield.
15. Birthplace: Maryland.

16. Informant: Mrs. George Jarman.
Address: Ocean City, Md RFD

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/7/45 (month) (day) (year)

Cemetery or crematory: Meadow Branch
Location: Westminster, Md

18. Funeral director: Anna A. Burbage
Address: Berlin, Md.

19. 5-7- (Date rec'd by registrar) 19 45 Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-4-45 19 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 19 44 to 5-4-45 19
and that I last saw h. alive on 5-4-45 19

Immediate cause of death	DURATION
Cereberal Hemorrhage	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. E. Abbott M. D. or other
Address: Berlin Md Date signed 5-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57d

CERTIFICATE OF DEATH

05454

Reg. Dist. No. 3SS

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin R R #3

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: James Robert Baker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 31 1940

8. AGE:

Years	Months	Days	If less than one day
4	6	10	hrs. min.

9. Birthplace: Berlin (Town, county, and state)

10. Usual occupation: Boy

11. Industry or business:

FATHER — 12. Name: Paul Baker

13. Birthplace: Berlin Md

MOTHER — 14. Maiden name: Nadine Truitt

15. Birthplace: Worcester Co

16. Informant: Paul Baker

Address: Berlin, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13 1945 (month) (day) (year)

Cemetery or crematory: Pine Church

Location: ~~Pittsville~~ Md. Gumboro, Del

18. Funeral director: M. Pasha Watson

Address: Salisbury, Md.

19. 5-13 1945 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1945, at 7-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Probably a tumor of the brain	Autumn
Due to growth	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John L. Riley Deb. Md Exam M. D. or other

Address: Snow Hill Md. Date signed: 5/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


MAY 18 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-0)

CERTIFICATE OF DEATH

05453

Reg. Diat. No. 350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Worcester

City or town: near Pocomoke City Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Just passing through

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Texas County: 121

City or town: Dallas

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 615 N. Washington St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Milton Barrett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	M.

8.(b) Name of husband or wife: Mrs. Tera Barrett

8.(c) If alive, give age: 17 years

7. Birth date of deceased (mo., day, yr.): Jan 3 - 1916

8. AGE: Years	Months	Days	If less than one day
31	4	16	hrs. min.

9. Birthplace: Wortell, Texas (Town, county, and state)

10. Usual occupation: Seaman U.S Navy

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace: "

MOTHER 14. Maiden name: "

15. Birthplace: "

16. Informant: Wife at Naval Base Chincoteague Va.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 25th 1945 (month) (day) (year)

Cemetery or crematory: Greenhill Cemetery

Location: Dallas Texas

18. Funeral director: Heiland Funeral Home

Address: Dallas. Texas.

19. May 19 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19th 1945, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on May 19 - 1945

Immediate cause of death: Injuries of Brain Fracture of Skull

DURATION: Instantaneous

Due to: auto collision with an auto truck

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 5-19-45

Where did injury occur? Main Highway (City or town) Worcester (County) Md (State)

Injured at home, farm, industry, public place (where?) Main highway

Means of injury collision auto truck Injured at work? No

23. SIGNATURE: N. E. Eastoms. M.D. M. D. or other

Address: Pocomoke City Md Date signed 5-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05455

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Eugene Prettyman Beauchamp.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married.

6.(b) Name of husband or wife: Walsie K. Beauchamp.

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): July 27, 1883.

8. AGE:

Years	Months	Days	If less than one day
61	9	16	..... hrs. ..... min.

9. Birthplace: Maryland (town, county, and state)

10. Usual occupation: Employee on boat

11. Industry or business

FATHER — 12. Name: John Wesley Beauchamp

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Taylor

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Walsie K. Beauchamp

Address: Ocean City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/15/45 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin Md

18. Funeral director: Anna B. Burbage

Address: Berlin Md.

19. 5-15 (Date rec'd by registrar) 1945 Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1945 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death:	
Carcinoma	
Due to: Stomach	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. R. Lay M. D. or other

Address: Berlin Md. Date signed 5-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

05456

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:

County Worcester.

City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Worcester.

City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Laura May Bounds.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow.

6.(b) Name of husband or wife Crawford Bounds.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 24, 1882

8. AGE: Years	Months	Days	If less than one day
63	0	8	..... hrs. ..... min.

9. Birthplace Providence Balto Co. Md
(Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business

FATHER 12. Name Erson Brown

13. Birthplace Maryland.

MOTHER 14. Maiden name Elizabeth Knight.

15. Birthplace Maryland.

16. Informant Miss Rebecca Bounds.

Address Berlin Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/3/45 (month) (day) (year)

Cemetery or crematory St. Pauls Churchyard

Location Berlin Md.

18. Funeral director Bruce A. Barbour

Address Berlin Md

19. 5-3 1945 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1945 19 at 11:58 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1945 to May 1 1945 and that I last saw h.. alive on May 1, 1945 19

Immediate cause of death	DURATION
Emphysematous Chronic.	2 yrs.
Due to	
Due to	
Other conditions Toxic (goitre) Thyroid	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank P. Lewis M.D.
M. D. or other

Address Millards Md. Date signed May 3, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-3)

T 05457

CERTIFICATE OF DEATH

Reg. Diat. No. 357

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Worcester

County

City or town: Eden (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred: R.D. #1,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (Not newborn infants give residence of mother)

State: Md. County: Worcester

City or town: Eden (If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. #1, (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Elizabeth Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Peter Francis Brown

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Aug. 13-1869

8. AGE: Years: 75 | Months: 9 | Days: — | If less than one day: hrs. min.

9. Birthplace: R.D. #1, Eden Md. (Town, county, and state)

10. Usual occupation: Home wife at Home

11. Industry or business

FATHER — 12. Name: Perry Hobbs

FATHER — 13. Birthplace: Somerset Co. Md.

MOTHER — 14. Maiden name: Mckaley Burnell

MOTHER — 15. Birthplace: Wicomico Co. Md.

16. Informant: Mr. Raleigh Brown

Address: R.D. #1, Fruitland Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 15-1945 (month) (day) (year)

Cemetery or crematory: Pine Lawn Mem.

Location: Somerset Co. Maryland

18. Funeral director: Hillsboro Co. Walter R. Holland

Address: Salisbury Maryland

19. 5/15/45 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13th 1945 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from Jan 28 1945 to May 13 1945

and that I last saw h[illegible] alive on May 13 1945

Immediate cause of death	DURATION
C.V. Valv. Stenosis	2 yrs
Due to: Chr. Art. Nephritis	3 yrs
Due to: Hypertension	?
Other conditions: Pelvic pelvis	?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed: 5/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-0

CERTIFICATE OF DEATH

05458

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 88 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Worcester.

City or town: Berlin.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Jennie Bowen Davis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow.

6.(b) Name of husband or wife: Horace Davis.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 12, 1857

8. AGE:

Years	Months	Days	If less than one day
88	2	16	..... hrs. ..... min.

9. Birthplace: Berlin Maryland.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Zadok Bowen.
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Trunkelein
15. Birthplace: Maryland.

16. Informant: Mr. Horace Dunkin.
Address: Berlin Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/31/45 (month) (day) (year)

Cemetery or crematory: Buckingham

Location: Berlin Md.

18. Funeral director: Anna A. Burbage

Address: Berlin Md.

19. 5-31-45 (Date rec'd by registrar) Helen F. Hayward (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1945 at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Chronic	
Due to: Interstitial Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

28. SIGNATURE: Chas R. Low M.D. M. D. or other

Address: Berlin Md. Date signed 5-31-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

05459 T

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Worcester
City or town: W. Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: W. Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: No Number
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Robert H. Hudson

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella W. Hudson
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Feb 19 1893

8. AGE: Years	Months	Days	If less than one day
52	2	16	hrs. ... min.

9. Birthplace: Berlin Md. (Town, county, and state)
10. Usual occupation: Store Keeper
11. Industry or business: Merchant

FATHER
12. Name: William A. Hudson
13. Birthplace: Del.

MOTHER
14. Maiden name: Rosiana McCabe
15. Birthplace: Del.

18. Informant: Mrs. Ella W. Hudson
Address: W. Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 6 1945 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Berlin Md.

18. Funeral director: M. Parks Watson
Address: Selbyville, Del.

19. 5-6- 1945 (Date rec'd by registrar) Helen L. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1945, at 4:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive on 5-4- 1945

Immediate cause of death	DURATION
Chr. Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Chas. R Law M. D. or other
Address: Berlin Md. Date signed 5-5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

CERTIFICATE OF DEATH

05460

Reg. Dist. No. 395

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or Institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: md County: Worcester

City or town: Berlin md (If outside city or town limits, write RURAL and give nearest town)

Street No. no (If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: William M Hudson

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	A.A.	Widower

6.(b) Name of husband or wife: Lottie Hudson

6.(c) If alive, give age: Don't know years

7. Birth date of deceased (mo., day, yr.): Oct 17, 1872

8. AGE: Years	Months	Days	If less than one day
72	7	1	hrs. min.

9. Birthplace: Berlin md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: same as above

FATHER — 12. Name: John A Hudson

FATHER — 13. Birthplace: Berlin md

MOTHER — 14. Maiden name: Sarah A Pillitt

MOTHER — 15. Birthplace: Berlin md

16. Informant: Charles E Hudson

Address: Berlin md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22-1945 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin md

18. Funeral director: James P Stewart

Address: Salisbury md

19. 5-21-45 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1945, at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Chr. Nephritis	
Due to	
Due to	
Other conditions Chr. Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas R. Law M. D. or other

Address: Berlin md Date signed: 5-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05461

CERTIFICATE OF DEATH

Reg. Dist. No. 354

1. PLACE OF DEATH:
County: Worcester
City or town: RURAL, Stockton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 Yeras
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: RURAL, Stockton (If outside city or town limits, write RURAL and give nearest town)
Street No. # Rt. 2 (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edward Jestice

3.(b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Annie Tull Jestice
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): February 5, 1895

8. AGE:	Years	Months	Days	If less than one day
	50	2	5	... hrs. ... min.

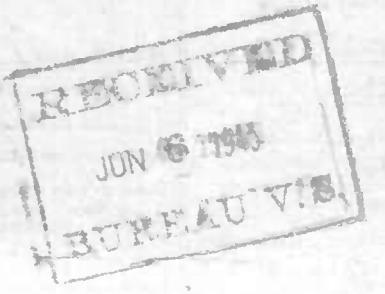
9. Birthplace: Stockton-Worcester-Maryland (Town, county, and state)
10. Usual occupation: Cooper
11. Industry or business: Barrel Factory
FATHER 12. Name: Moses Jestice
13. Birthplace: Worcester County, Maryland
MOTHER 14. Maiden name: Emmaline Bratten
15. Birthplace: Worcester County, Maryland
16. Informant: AAron Collins
Address: Stockton, Md. # Rt. 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22, 1945 (month) (day) (year)
Cemetery or crematory: Old St. Pauls Cemetery
Location: Stockton, Md. # Rt. 2
18. Funeral director: H. Harvey Bardshaw
Address: Pocomoke City, Md
19. May 21 1945 (Date rec'd by registrar) Mary M. Tyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1945, at 10:05 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 1945, to May 19 1945
and that I last saw h... alive on May 17 1945
Immediate cause of death: [illegible] DURATION [illegible]
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address [illegible] Date signed [illegible]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T 05462

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20)

CERTIFICATE OF DEATH

Reg. Dist. No. 350

VS A15 (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 73 Years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Walnut St
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Moses Pierson Jones

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Addie M. Jones
6.(c) If alive give age: 70 years

7. Birth date of deceased (mo., day, yr.): December 27-1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
73	5	3		

9. Birthplace: Pocomoke Worcester Md
(Town, county, and state)
10. Usual occupation: Farming & Carpenter
11. Industry or business: —

MOTHER FATHER
12. Name: Moses A. Jones
13. Birthplace: Maryland
MOTHER
14. Maiden name: Henrietta Davis
15. Birthplace: Maryland

16. Informant: Mrs Edna Jones
Address: Pocomoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 3 1945 (month) (day) (year)
Cemetery or crematory: Hall's Hill Baptist
Location: Pocomoke Md.

18. Funeral director: Marguette L. Dotson
Address: Pocomoke Md

19. June 1 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30th 1945, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1945, to May 30 1945
and that I last saw h. alive on May 29 1945

Immediate cause of death	DURATION
Sudden collapse	1/2 hrs
Due to: Heart Insufficiency Tobacco	15 hrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: O. M. Wilson M. D. or other
Address: Pocomoke City Date signed: May 31. 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

05463

Reg. Dist. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Worcester
City or town: Near Snow Hill
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Near Snow Hill
(If outside city or town limits, write RURAL end give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Nattie L. Martin

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: David Martin
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Aug 23 1884

8. AGE: Years: 60 | Months: 8 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Snow Hill Md
(Town, county, end etate)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Caleb Lawes
13. Birthplace: Snow Hill Md

MOTHER
14. Maiden name: Lizzie Beake
15. Birthplace: Snow Hill Md

16. Informant: David Martin
Address: Snow Hill Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 24-45 (month) (day) (year)
Cemetery or crematory: M. E. Cemetery
Location: Snow Hill Route #2

18. Funeral director: Evans & Dennis
Address: Snow Hill Md

19. 5/21/45 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 19 45 at 9.50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from — 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

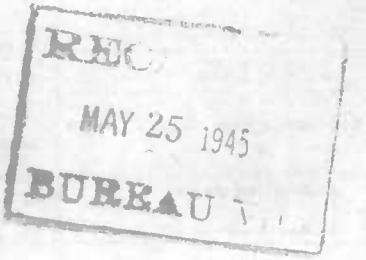
Immediate cause of death	DURATION
Myocardial degeneration	
of Heart	
Due to —	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John L. Riley Dep. Med. Exam. M. D. or other
Address: Snow Hill Md Date signed: May 24 45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MAY 25 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

05464

Reg. Dist. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Worcester
City or town: Rural Snidletree
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Rural Snidletree
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sallie F. Selby

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William E. C. Selby
8.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): June 12 - 1894

8. AGE: Years	Months	Days	If less than one day
50	11	5	..... hrs. ..... min.

9. Birthplace: Accomac Virginia
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Major S. Truitt
13. Birthplace: Md

MOTHER
14. Maiden name: Elizabeth Curtis
15. Birthplace: Virginia

16. Informant: William E. C. Selby
Address: Rural Snidletree Md

17. Burial (Burial, cremation, or removal, which?) Date thereof: May 20 1945 (month) (day) (year)
Cemetery or crematory: Baptist Cemetery
Location: Pocomoke City Md.

18. Funeral director: Marguerite H. Watson
Address: Pocomoke City Md

19. 5/20 1945 (Date rec'd by registrar) L. Roy Truitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1945, at 4:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24th 1945 to May 16 1945
and that I last saw h... alive on May 17 1945

Immediate cause of death	DURATION
Due to: Chronic Bronchitis	Several yrs
Due to: Colds & repeated attacks of Bronchial Asthma	"
Other conditions: Anemia	D K

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. C. Stevens M. D. or other
Address: Pocomoke City Md Date signed: 5/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

T 05465

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill Rural #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill Rural #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Frank E Tarr

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nida L. Tarr

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): April 11 1887

8. AGE: Years: 57 | Months: 1 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Stockton Worcester MD
(Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business: Oyster & Bay

FATHER
12. Name: William C. Tarr
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah L. Keely
15. Birthplace: Maryland

16. Informant: Mrs. Nida L. Tarr
Address: Snow Hill MD Rural #1

17. Burial, (Cremation, or removal. Which?) Date thereof: May 14 45
(month) (day) (year)

Cemetery or crematory: Riverside
Location: Stockton, MD

18. Funeral director: Pearre Dennis
Address: Snow Hill MD

19. 5/12 1945 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1945, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 23 1945 to May 12 1945 and that I last saw h wife alive on May 12 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	2 Hrs
Due to: Hypertensive Cardiovascular renal disease	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert E. LeMar, MD
M. D. or other
Address: Snow Hill Date signed: 5/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0546 T

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill R.F.D. 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Worcester
City or town: Snow Hill mdR F D #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Frank T. Webb.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	married

6.(b) Name of husband or wife: Belle Webb.
6.(c) If alive, give age: 74 years
7. Birth date of deceased (mo., day, yr.): April 9, 1865

8. AGE: Years: 80 | Months: 0 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Minos Webb.
13. Birthplace: Maryland
MOTHER 14. Maiden name: Hetty Bradford
15. Birthplace: Maryland
16. Informant: Mrs. Clayton Moore
Address: Snow Hill Md R.F.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/9/45 (month) (day) (year)
Cemetery or crematory: New Hope
Location: Willards Md R.F.D.
18. Funeral director: Anna B. Burbage
Address: Berlin, Md.
19. May 7 1945 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1945, at 830A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15 1944 to May 6 1945
and that I last saw him alive on April 15 1945

	DURATION
Immediate cause of death: Acute Coronary occlusion	1 hr
Due to: Senility & arteriosclerosis	10 yr.
Due to:	
Other conditions: Parkinsons Encephalopathy	18 yr

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert L. La Mar, MD M. D. or other
Address: Snow Hill Date signed: 5/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15